Comprehensive Wound Management to Your Door…

Wound & Medical Outreach Clinic LLC

www.wmoclinic.com Contact@wmoclinic.com Administrator@wmoclinic.com NPI Group 1881229532
Fax (800) 351-2611Voice & Appt (813)777-1591

REFERRAL/CONSULT REQUEST FOR_____(PATIENT NAME)

PHYSICAL ADDRESS_____
CONTACT NAME (POA IF APPLICABLE) &PHONE _____
FOR MEDICAL PPE HOUSE CALL OR TELEHEALTH VISIT WITH WOUND & MEDICAL OUTREACH CLINIC.
CALL (813) 777-1591 OR FAX TO (800)351-2611

Please attach demographics, most recent H&P, Med List, Medical Notes, HH admission notes IF AVAILABLE

Referral/Consult Requested By (Name) _____ Direct Requestor Phone _____

of (Agency/Facility) _____ Fax #_____

Primary Care Provider_____ Fax _____Phone_____

Address_____

On Site Residential PPE Visit Requested _____ Screen for Telehealth Visit ____Email Contact_____

Referral/Consult Request for Medical Home Visit by Provider(s) of Wound and Medical Outreach Clinic, LLC for Evaluation & Management of:_____

____Comprehensive Medical Wound Management Evaluation and Plan of Care for Chronic Wound/Skin Disorder
____ Non-Healing Wound(s)/Injuries/Incision Body Part(s)_____
____ Abnormal Dermatologic Findings: ____Rash ___Lesion ____Other: _____
____ Management to prevent re-occurrence of High-Risk Chronic Wounds
____Abscess, Abnormal Lesion, Skin/Cyst Infection
____Other Diagnosis: _____

Patient Information (May Attach Demographic Form with Info Below) ___See Attached

Name as on Insurance Card_____
Is Pre-Authorization required from Insurance Company or Primary Care Prior to Referral? Yes No
(May Skip Below if Demographic Sheet Attached with Below Information_____)
Patient Current Physical Address_____
Patient Home Address on File with Insurance Co if different_____
_____,
Date of Birth_____ Best Day Time Phone #_____
Best Email or Cell Phone _____ (for Telehealth Virtual Visit)
Legal Representative (if applicable) Name_____
Contact Legal Representative for all information and care coordination? Yes No
Primary Insurance_____ ID #_____
Group # _____ Customer Service/Verification Phone_____
Secondary Insurance_____ ID #_____
Group # _____ Customer Service/Verification Phone_____
***If Available PLEASE ATTACH AVAILABLE MEDICAL HISTORY & PHYSICAL, PROGRESS NOTES, NURSING ADMSSION**

DO NOT HESITATE TO CALL TO DISCUSS OR FOR ANY QUESTIONS (813)777-1591
OR EMAIL CONTACT@WMOCLINIC.COM